Female employment, status and working conditions in French hospitals, a convergence between public and private sector despite differences in industrial relations ?

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Abstract

The French hospitals sector is split between sub-sectors, with different employment status (civil servant versus private employment contract). Industrial relations differs. Nevertheless, differences between the sub-sectors are not very important. Quality rules and health regulation could explain why different labour market institutions do not lead to a strong divide in employment and working conditions.

Introduction

As in some other European countries (Germany, Jaherling, 2007), the French hospital sector is divided between a dominant public segment, a non for profit and a for profit segment. If these segments are not strictly on the same activities, nevertheless, they are in competition for patients, mainly between the public and the for profit segments. Another dimension of the competition is the labour market. In both segments, they compete mainly for skilled workers but also for semi-skilled and at a less degree unskilled one's (Nurse, Nurse assistant and various kind of cleaners and others low skilled workers) : same type of jobs, mainly female work,.

The institutions on the labour market are quite different. In the public sector, the French civil servant status is predominant, but one can notice a growing use of private contracts (fixed term) at the boarder of the classical public status. In the private for profit sector, the labour contract is a classical open ended contract, but one can notice also an use of fixed term contract, of temp agencies.

In both cases, the core female workers are very stable and, at the periphery, a reserve army is waiting for permanent jobs. This periphery is ruled by mimicry to the core labour market, with implicit seniority rules. Work organisation and working conditions do not differ a lot.

Despite different level and forms of unionisation, the two sub-sectors seems to be highly articulated. It is partly due to the fact that most unions are gathering in the same organisation the workers of the private and of the public sector. It is also probably due to the competition on the labour market. But another hypothesis is the strength of the public « quality rules » which are imposed in the same way to the two segments.

In a first section, we will briefly present some characteristics of the sector. In a second section, we compare the main work and employment characteristics of the low/semi skilled segment of the work force. In a third section, we will discuss the factors explaining the divergent and convergent trends between the two sectors.

This paper relies on the general methodology identified for research on "low-wage work." It uses a set of national statistical data, primarily from the Ministry of Health (in particular, annual statistics on health institutions and the 2003 survey on working conditions in hospitals). Eight case studies were done in 2005 and 2006 on mid-sized hospitals and clinics (100 to 800 beds, excluding university hospitals). Four are public hospitals, four are private for-profit clinics. Four are located in labour markets with a high rate of unemployment and four in tighter markets. In each case study, between twelve and fifteen in-depth interviews were conducted with hospital management (executive director, human resources manager, nursing care manager), union leaders, nurse's aides (NAs), and hospital service workers (ASHs), primarily in medical units. In one case, a hospital that subcontracts some of its work, the interviews also dealt with the subcontractor's business and workers. We thanks the Russell Sage foundation for its support.

1.Public/private for profit hospitals : an institutional divide

For historical reasons, the French hospitals have been divided in three sub-sectors : a dominant public one, a private non for profit one and a private for profit. Size, medical specialities, employment status of the work

force are different. In the following who will focus only on the public and the for profit sectors, which are dominant in the MSO activities.

1.1 The tow sub-sectors

A public hospital sector whose vocation was to care for the poor gradually came to coexist with a voluntary and for-profit private sector intended primarily for well-off patients. That for-profit sector, overhauled in the late 1950s, grew significantly until the 1990s, while granting access to less fortunate members of society. For its part, the public hospital underwent a transformation, becoming more attractive and less restricted to the working class. As a result, and within a context of intense budget constraints, the private sector has lost ground in the last ten years.

For medical, surgical, and obstetric (MSO) services alone, on which this paper deals more specifically, the for-profit private sector represents 26 percent of beds, the public 65 percent, and the non for profit sector 9 percent. The for-profit private sector is undergoing a strong trend toward concentration, with a drop in the number of establishments and a rise in their size. In medicine, the average number of beds per establishment has risen from 70 to 84. The public sector is also experiencing a reduction in the number of establishments, but the average number of medicine beds per establishment has fallen as well (from 220 to 210).

Specialization is high in the for-profit private sector. That is particularly true for surgery (where its share is rising), for obstetrics (where its share has recently dropped), and for certain medical disciplines, but also for medium-term care (primarily follow-up and convalescent care). That specialization is part of a quest for profitable “niches”—costly medical procedures (fitting prostheses, for example) and predictable care services that ensure a high use rate for technical equipment and beds. Within our sample, all the private clinics were 100 percent specialized in MSO services. Nevertheless, they belonged to groups with other operations, retirement or convalescent homes, for instance. Public hospitals are more diversified and more integrated, with a mix of MSO and psychiatric services and sometimes an integrated retirement home.

1.2 Civil servant and private labour contracts

Unlike the United States (Appelbaum et alii, 2003) and European countries other than France, the majority of workers in public hospitals are civil servants (about 80 percent). Because of the scope of these public hospitals, civil servants hold more than half of all jobs in the hospital sector as a whole (public and private). In 1955, wage regulations were applied uniformly in all public hospitals. These regulations were renewed in 1986, becoming totally integrated into civil service regulations. They govern all questions relating to hiring, mobility, wages, bonuses, and leaves. They are subject to negotiations and adjustments between the state, the unions, and public hospital representatives and can be compared to a collective bargaining agreement. But the state plays a determining role. For example, annual wage increases are decided by the central government for the entire public sector, hospitals included. A “licensed”[i] hospital worker is recruited “for life.” But the unions play a major role through a set of structures of representation, both at the individual hospital level and at the national level. The force of civil service regulations characteristic of the French model explains the homogeneity in our public hospitals.

In the for profit hospitals, one collective agreement applies to all the hospitals. As usually in France, it is bargained at the sectoral level, and later made compulsory by a state regulation. Nevertheless, private hospitals have a greater room for manoeuvre than in the public sector. In the past, the local arrangements had to be on the benefit of the employees (better advantages than in the collective agreement). Since 2004 a kind of opt out clause has been introduced in the French private industrial relation system. It was too early when our case studies were done to grasp the impact of this new law. But according to an other research, the employer organisation is not so keen to use it (Jobert, Saglio, 2005). Nevertheless, the sectoral organisation could be said as a weak one. Most of the hospitals are small organisations. And when they are owned by doctors, the owners do not regards themselves as “employers” and are unlucky to follow labour market regulations.

This institutional context, the market direct pressure on the for profit sector could lead to high differences in the employment and working conditions. In the next section, we will see that the differences are not so strong. The within variation is sometimes higher than the between one.

2.Employment and working conditions : less differences than forecasted

It is not possible to review all the employment and working conditions. We will concentrate on some key characteristics

2.1The prevalence of internal labour markets

In the case of NAs and ASHs, hospitals (public or private) exemplify the internal labour market in the sense defined by Doeringer and Piore (1971), particularly since seniority is respected when workers move from one institution to another. Wage progression is guaranteed once a worker has entered the internal market and the turnover rate is very low. Internal !mobility, vertical or not is also quite frequent (Arborio, 2001). The table below summarizes the major national data.

Table 1 : indicators of ILM

	Public			private for profit		
	N	NA	ASH	N	NA	ASH
Seniority> 10 years	57%	62%	60%	47%	58%	54%
Changing hospital*	6%	6%	1%	2%	3%	1%
Wage seniority gap**	43%	39%	20%	31%	30%	23%

*2001/2003

** 3-6 years/>20 years, full time

Source : Dress, survey on working conditions 2003, authors' calculations.

Civil service regulations are, of course, playing a major role. But seniority in private clinics is also important and the turnover rate very low. Policies in private hospitals are designed to produce a loyal workforce. In addition to the wage benefits linked to seniority—stipulated by the collective agreement—there are non-wage benefits, sometimes associated with a strong paternalistic policy (loans to alleviate financial troubles, housing assistance in two clinics). The internal market model in the private sector is thus similar to that in the public sector.

2.2Wage differential

In both sub-sectors, wage progression based on seniority is significant, more for NAs than for ASHs (see table 1). Lifetime wages are better for NAs in the public sector than in the private, a cause for complaints about the collective agreement structure in some clinics. For ASHs, conversely, the financial benefit of seniority is slightly better in the private sector.

In both sub-sectors, various fringe benefits supplement the base salary. First, there is a year-end bonus, the equivalent of a month's wages, theoretically adjusted in the public sector to reflect employee absences. In the private hospitals, the year-end bonus took the form of profit-sharing. But in two of the clinics, a conflict arising in the wake of France's compulsory thirty-five hour workweek has turned that profit-sharing benefit into an "automatic" year-end bonus granted to everyone. Second, there are bonuses related to scheduling (overtime pay for night and weekend work) and to working conditions. These benefits, taken together, can amount to 20 percent of base salary. They are all automatic, linked to the particular job. There was no individualization of salary in any of the cases studies.

Nevertheless, the wage differential between the public and private sectors remains in force, to the advantage of the public sector. In 2000 (Brahami, 2002), these differences were fairly large. By 2003 (Collet, 2005), the gap had narrowed, the result of the universal application of the thirty-five hour workweek and more rapid wage increases in the private sector. But all things being equal, wage scales remain 11 percent lower in the private sector.

That difference is noticeable in the case studies. Workers in the private sector mention discrepancies of 200 to 400 euros a month compared to the public sector. These discrepancies account for the greater labor demands being voiced in the private sector. Hence, in two clinics, wage disputes primarily targeted the methods for granting benefits. In the public sector, conversely, the disputes tend to be national, linked to the general modalities for granting wage increases in civil service jobs. But these discrepancies do not lead to a very high mobility of employees from the private to the public sector. Several reasons for this can be put forward: the cost of such mobility, given that access to the public sector is competitive and waiting lines are already very long; organization of work time (more regular work schedules are often mentioned as an advantage in the private sector); the smaller size of private clinics, where the work atmosphere is judged more convivial than in public hospitals (said to be "like factories"). A few of the employees polled (especially NAs) who had a chance to enter the public sector nonetheless chose the private sector, despite lower wages.

2.3External flexibility and the labour army reserve

If most of the employees are in the core work force, all our hospitals are managing and external "labour reserve army". Various reasons, ranging from the need of a productive flexibility (operating 365 days a year, wage costs, better malleability of the work force… are emphasizes by the managers. Two main solutions are coexisting.

a)The first solution is outsourcing. This is mainly used for catering, cleaning common areas and washing linen and sometimes for more specialized functions (informatics, recurrent works on the building)[ii]. Here , it is necessary to underline the importance of labor market institutions. When writing contracts with external providers, it is stated that the provider that wins the tender offer will keep employees. As in Great Britain, we find "permanent" employees under the authority of the provider or entirely transferred to the providers' management. A private hospital is the only case of total outsourcing of cleaning services. At the moment of our research, outsourcing was in course, justified by the directions' aim of simplifying management (due to the small size of the clinic), rather than economizing. An assessment was not possible at the time, but consequences are strong. ASH became the providers' employees, were attached to their collective agreement and, symbolically, carry their blouse. Their salary levels were maintained in principal, but there is great confusion concerning the different structures (namely integrated bonus or not). Interviewed employees considered that they had lost certain benefits and were concerned with upcoming evolutions. As for the manager of the subcontracting company, he foresees that future hiring will be made at minimum wage. Furthermore, problems concerning quality are emerging.

b)The second solution is the use of a wide range of atypical contracts, which are more or less breaking with the civil servant status and the private collective agreement. Table 2 provides our results for private and public hospitals. On of the key characteristic (which is classical on the French labour market) is the higher use of theses solutions by the public sector. On the one hand, public hospitals have strict binding rules regarding the level of the employment of civil servants. On the other hand, the duration of the waiting list before being licensed is longer than in the private sector (see Causse, Méhaut 2007 and Arborio Méhaut 2007 for a deeper analysis).

Table 2 : Strategies regarding the atypical contracts

Contract **Cases**	**Short fixed term**	**Long fixed term (>3 months)**	**Open ended**	**Public scheme**	**Temp.**	**% (Equivalent full time)**	**Concentration**
Apub	Yes	Yes	Yes	Numerous	No	18%	ASH
Cpub	Yes	Yes	Yes	Numerous	No	36%	ASH/NA
Bpub	Yes	Numerous	No	Yes, weak	No	18%	ASH 52%
Dpub	Yes	Yes	No	Yes, weak	No	24%	ASH 44%
Gpriv	Numerous		*	*	No	n.a.	ASH/NA
Fpriv	Numerous	Numerous	*	*	Yes	14%	ASH/NA
Rpiv	Yes	Yes	*	*	Yes	12,5%	ASH/NA
Epriv	Yes	Yes	*	*	Yes	16,5%	Inf/NA/ASH

2.4 Working time

The 35 hours regulation applies to both sectors. It was implemented earlier in the private for profit hospitals, and usually with a higher number of job creations than in the public one. The public hospital sector is regarded as one of the sector were the 35hours regulation has the worse consequences on the work load. In our case studies we found more complaint about this workload in public hospitals.

In our case studies, choices regarding the shift and weekly working time organisation are different. In 3 among our 4 private hospitals the work schedules tend toward longer days than in the 5 other cases (ten to twelve hours, 7/8 hours in the others). Over the course of a month, workers alternate between a "short" week (three workdays) and a "long" week (five days, including a weekend). The long-day schedule tends to be valued by the staff: there is a greater predictability of schedules, more days off, no alternating between getting up early and getting home late, and less commute time. That benefit accounts for some of the appeal of the private sector and partly compensates for lower wages. In both sectors, part time is expanding, more quickly for the NA than for the ASH. But the private sector clinics in our sample try to limit part-time.

2.5 Work organisation

In our sample, we found differences between hospitals regarding the work organisation, but it was not possible to differentiate the public/private strategies (see Méhaut, 2007 for more details).

The NAs are usually performing the same basic tasks (they are qualified NAs, with a compulsory qualification, and the boarder with the nurses' tasks are defined by what a nurse can perform as "medical acts". In all our cases studies, NAs' job profile is quite similar : a mix of elementary nursing, cleaning tasks, contacts with the patient and its family, nutrition, some basic medical acts (measuring glycaemia), and participation to the wards' coordination (meetings, knowledge of the patient file…). When differences occur, they are linked on the one hand to relationship with the nurses (close cooperation or not) and on the other hand to the position of the ASHs. In the former case, one can hardly speak of hospitals' strategies ; it is more the product of the working community at the ward level. In the later case, hospitals strategies account.

In the traditional organization of a hospital, the ASH is also an integral part of the unit. Her main job is to clean the rooms (empty or occupied) and common areas. Theoretically, the area around the patient is cleaned by the NA. The two may work together, in making up empty beds, for example. In addition, depending on the hospital's organizational choices but also on the staff arrangements within the units, she may distribute pitchers of water to the patient, do the dishes, and distribute or help in distributing meal trays. ASHs may also help to get a patient into a chair, may reply when the patient buzzes for help, and may sometimes run a few errands. In hospitals where ASHs are most thoroughly integrated into the unit, they also attend change-of-shift meetings and are familiar with pathologies, with the particular cases. They often have contact with patients and their families. But we found also in half of our cases studies a trend towards a more tayloristic specialisation of the ASHs as cleaners, on the model of the hostels housekeepers (restricting and/or forbidding the contact with the patient). Again, here it was the case in some public hospitals as well as in some private one's.

In conclusion of this section, we must emphasized that, starting with an a priori clear contrast between the private and the public sector, we ended with a more burred picture. The same fundamental model of employment seems to be at work in both sectors.

3.Public/private hospitals : a common model of employment ?

The French employment and social model is usually characterised by a strong opposition between the private and the public sector (Askenazy and alii, 2007). The civil servant status is regarded as the best one and is a kind of reference for most of the unions' claims, namely regarding the employment stability. In the hospitals sector, the figure is more blurred. As in the whole public sector (xx, xx) , wages (at the bottom of the hierarchy) are higher in the public sector. Employment stability does not differ and moreover, the public sector provides a higher share of atypical contracts… How to explain such similarities ? We develop now four main arguments.

3.1 A common system of production

The first one, very classical in the literature, is the technical argument : for the same product, with the same technologies, there is one best way. Mainly developed for the industrial sector, this argument could also be applied to the health sector. Speaking about our categories (NAs and AHS), we must take the technology in a broad sense : on the one hand the structure of the building and, on the other hand, the organisational choices. Most of our hospitals are still organised around wards, which are at the core of the production organisation. And the traditional ward of the 70's was an integrated one, mixing the various ingredients of the productive system (medical cure, care and housing). Moreover, most of the hospitals (private and public) in our sample were build or rebuild at the end of the 60's, beginning of the seventies. The internal organisation of the building fits with the "ward model" and, when we were in a ward during our survey, it was quite impossible to say if it was a public or a private hospital. Last but not least, the management tools (for example to analyse the work load, the employment needs) are often outdated and the same in both sectors.
Nevertheless, this technological argument is also put in question in a lot of international comparisons, which put emphasis on the "societal effect", on the varieties of capitalism…(Maurice, Sellier, Silvestre, 1982) In the hospital sector, we found also huge differences between countries despite the same system of production. So other arguments must be mobilized.

3.2 The coordinated industrial relation system

Despite the fragmentation of the unions (5 main unions for the hospital sector, but also other specific unions and other professional organisations), the public and private employees are often organised within a same sectoral federation. If local coordinations are sometimes weak, exchanges at the national level are stronger. And very often, the civil servant status is used as a kind of benchmark in the unions' claims. The public sector continues to lead wage settlements and has sustained a relatively wide premium in average pay – at around 11% (Collet, 2005). It generates pressures towards greater coordination. Indeed, during the drafting of the new collective agreement of the private sector hospitals in 2002, it was stated that, "the parties intend to further improve the employees' work conditions, in the framework of a convergence of wage rates of public

and private hospital employees.". Employers organization, on the other side, are keen to avoid poaching strategies. They claim also for a levelling of the employment and wages conditions.

In the case of Germany, the levelling process seems to be a downward spiral (Jaerhling 2007). It is not yet the case in France. The highly centralised system of collective bargaining, the role of the state acting also in the private sector, the importance and attractiveness of the civil servant status (half of the total work force) exert common pressure on the two sub sectors.

3.3 The pressure of the labour market

Today, with the rather high level of unemployment, especially for unskilled women workers, it is difficult to speak of tight labour markets. In our sample, we choose private and public hospitals in various local areas, with low or high level of unemployment. This contrast was not operating to explain differences (except for the use of public schemes in public hospitals). All our hospitals do not face any problem to recruit ASHs. For this category, labour market pressure is not strong. Moreover, both public and private subsectors are offering wages and employment conditions which are better than in other sectors such as retail or hostels. This attractiveness could allow different trends between private and public hospitals. It was not the case. So other explanations must be mobilised. Moreover, looking at the other categories (NAs and Nurses) one can see that on the one hand the common standard of qualification push towards a convergence. On the other hand, tighter labour markets exert also pressures for a wage harmonisation. In some of our case studies, the private clinics were offering wages for the nurses 15% above the collective agreement (and sometimes above the public hospitals), in order to retain nurses. For the NAs, some of the HRM managers were complaining about the collective agreement, not very attractive compared to the public civil servant status. No clear solutions were provided. But again, the NAs' labour market was said as quite soft. Nevertheless, if the employment forecast are true (lower unemployment rate in the future, tensions in all the jobs related to health and home care), the "law of the market" could be reinforced, pushing first the private sector to offer better wages...and may be in a later step, putting in question the public sector grids.

3.4 The health regulations : same pressures and quality rules ?

Regulations governing the health system have a major impact, in that they are common to public and private hospitals. The two sub sectors depend on the same major source of financing (the national social security system) and on similar financing rules. In the recent time, they will follow the new DRGs funding principle (to be fully implemented in the next years). Some official reports are emphasizing the differences in wages costs between the various sub-sectors (Bartoli, Bras, 2007). They conclude to the need of an harmonisation of these conditions...but on what bases ? The upper, the average, the lower ? Clearly its is not a "market led choice", as in this case, some hospitals will disappeared. And the State and the health authority want to control the supply of health provision in a local area. Moreover, Public authorities are pushing towards more integration between the public and private sector : cooperation in the supply of services, sometimes, grouping the hospitals (private and public in the same building to share some in-house services). One of our case study was an experiment in this way. At the time of our survey, The private clinic and the hospitals were in the same building. Some civil servant where sometimes working in the private clinic and some private employees in the hospital. Whether a "two tiers" labour force will remains and/or develops (on the UK model of the PPI) was unclear. But the strongest hypothesis would be a levelling of the wage differential, and a stable divide between private and public employment status.

Moreover, private clinics and public hospitals are subject to a set of norms that play a role in standardizing job descriptions and working conditions. They concern the conditions for operating a hospital: for example, there is a minimum requirement for the number of nurses and nurse's aides on the job. They also increasingly concern a certain number of procedures that must be respected, and these have a direct influence on the nature and volume of the staff's work: respect for the patient, codified in the charter of patient's rights and duties, rules for pain management, and hygiene regulations designed to fight nosocomial infections. These rules, which are similar to the quality control practiced in industry, influence job description (definition of protocols and procedures), accountability (records kept in the patient's file), and the skill level and structure of the labor force. In most of our case studies, both public and private hospitals were engaged in a trend to upgrade the skills' levels, both for the NA (eradicating the unqualified NAs) and for the ASHs (hiring only qualified ASHs with a basic VET).

Conclusion

The health sector, despite high differences in its structure and its funding remains, in most of the european countries highly controlled by the state or a public health authority. An obvious tension exists between the quality of the care and the cost control. As in most services, the wage costs represent a significant share in the hospitals expenditures and as the budget pressure is stronger and stronger, hospitals are looking for

various solutions. Increasing the productivity is a first way. This increase is mainly implemented by the shortening of the lengh in stays, due to the evolution of the medical technologies (more and more day care) rather than by an increase of the work load of the employees in the classical wards. And due to the tension between quality and costs, the health authority is maintaining or reinforcing its controls over the quality, including the well being of the patient, the cleaningless of the hospitals. In the Netherlands (Van der Meer, 2007) and in the UK (Grimshaw, Caroll, 2007), where the public hospital sector is the only one, a highly coordinated system of industrial relations is remaining or reinforcing (UK). Combined with the quality control of the health authority, it produces rather homogenous employment and working conditions for the employees (including recent new trend in the UK where the outsourced work force has to be treated in a similar way as the hospitals work force). In France, despite an heterogeneous hospitals' sector, the weakest part of the work force (semi or unskilled women) seems, today, benefiting of better conditions than in other female services sector. The quite centralised and coordinated industrial relation system and the quality rules (common to public and private hospitals) are producing an homogenity which looks like the NL or UK situation, despite the differences and competition between the public and the private sector, and despite the high level of unemployment for the unskilled women. Germany, (Jaerhling, 2007) is a different national case where a negative spiral is at work, and where the public sector is following the "low road" of the private one. This is a puzzling question for a future comparison.

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[i] In what follows, we use the term “licensed” to designate civil servants in the public sector. By extension, it will also be used to designate workers with an unlimited-term contract in the private sector. That is the word used by everyone we met to differentiate permanent workers from those with limited-term contracts.
[ii] On the contrary, some public hospitals (Mpub, Apub) will keep their laundry service for example and will be providers for other hospitals or nursing homes.